

		FOR OHF USE					

LL 1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036640</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Alden Valley Ridge Rehab & HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>275 E. Army Trail Rd.</u> <u>Bloomington</u> <u>60108</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>DuPage</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Steven M. Kroll</u> (Title) <u>Chief Financial Officer</u>	
Telephone Number: <u>(630) 893-9616</u> Fax # <u>(630) 924-1059</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>36-3738956</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>02/01/91</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Valley Ridge Rehab & HCC# 0036640 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>207</u>	Skilled (SNF)	<u>207</u>	<u>75,762</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>207</u>	TOTALS	<u>207</u>	<u>75,762</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,815</u>	<u>2,998</u>	<u>3,640</u>	<u>16,453</u>	8
9	SNF/PED					9
10	ICF	<u>34,772</u>	<u>4,906</u>	<u>2,491</u>	<u>42,169</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,587</u>	<u>7,904</u>	<u>6,131</u>	<u>58,622</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.38%

D. How many bed-hold days during this year were paid by Public Aid?

9 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)day acre

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 18 and days of care provided 2,783Medicare Intermediary AdminiStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Alden Valley Ridge Rehab & HCC # 0036640 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	359,488	58,079		417,567	1,358	418,925		418,925		1
2	Food Purchase		423,625		423,625	(42,506)	381,119	(4,534)	376,585		2
3	Housekeeping	177,600	29,040		206,640	537	207,177		207,177		3
4	Laundry	73,457	16,123		89,580	150	89,730		89,730		4
5	Heat and Other Utilities			207,804	207,804		207,804		207,804		5
6	Maintenance	44,460		219,508	263,968	3,128	267,096	4,397	271,493		6
7	Other (specify):*										7
8	TOTAL General Services	655,005	526,867	427,312	1,609,184	(37,333)	1,571,851	(137)	1,571,714		8
	B. Health Care and Programs										
9	Medical Director			17,100	17,100		17,100		17,100		9
10	Nursing and Medical Records	2,271,078	90,909	5,201	2,367,188	3,976	2,371,164	(631)	2,370,533		10
10a	Therapy	11,594			11,594	300	11,894		11,894		10a
11	Activities	73,896	7,018	2,498	83,412	92	83,504	(5,995)	77,509		11
12	Social Services	35,178		618	35,796		35,796		35,796		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,391,746	97,927	25,417	2,515,090	4,368	2,519,458	(6,626)	2,512,832		16
	C. General Administration										
17	Administrative	71,503			71,503		71,503		71,503		17
18	Directors Fees										18
19	Professional Services			672,383	672,383	(300)	672,083	(605,585)	66,498		19
20	Dues, Fees, Subscriptions & Promotions			52,618	52,618	(3,128)	49,490	(36,478)	13,012		20
21	Clerical & General Office Expenses	556,220	18,087	45,620	619,927	261	620,188	59,922	680,110		21
22	Employee Benefits & Payroll Taxes			466,834	466,834	36,132	502,966	56,434	559,400		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,333	1,333		1,333	15,471	16,804		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,900	4,900		4,900	52,580	57,480		26
27	Other (specify):*										27
28	TOTAL General Administration	627,723	18,087	1,243,688	1,889,498	32,965	1,922,463	(457,656)	1,464,807		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,674,474	642,881	1,696,417	6,013,772		6,013,772	(464,419)	5,549,353		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alden Valley Ridge Rehab & HCC #0036640 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			65,539	65,539		65,539	336,515	402,054			30
31	Amortization of Pre-Op. & Org.							22,962	22,962			31
32	Interest			96,551	96,551		96,551	665,594	762,145			32
33	Real Estate Taxes							134,639	134,639			33
34	Rent-Facility & Grounds			1,025,084	1,025,084		1,025,084	(1,025,084)				34
35	Rent-Equipment & Vehicles			8,125	8,125		8,125	21,207	29,332			35
36	Other (specify):* mortg. Insur.							44,003	44,003			36
37	TOTAL Ownership			1,195,299	1,195,299		1,195,299	199,836	1,395,135			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		155,590	364,244	519,834		519,834	(213,850)	305,984			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,643	113,643		113,643		113,643			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		155,590	477,887	633,477		633,477	(213,850)	419,627			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,674,474	798,471	3,369,603	7,842,548		7,842,548	(478,434)	7,364,114			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$ (6,295)	11	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,755	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,374)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,716)	32		18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,021)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,950)	20		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9,630)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,281)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(293,787)	vary	34
35	Other- Attach Schedule see pg 5a	(149,366)	vary	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (443,153)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (478,434)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1			1
1	non-cost for part b therapy c/a in 5212/3/4	(5,856)	39
2	non-cost for hmo oxygen c/a in 5080	(459)	39
3	non-cost for hmo therapy c/a in 5040	(81,959)	39
4	non-cost for hmo drugs c/a in 5042	(18,318)	39
5	non-cost for hmo radiance c/a in 5093	(2,079)	39
6	non-cost for hmo therapy c/a in 5026	(5,365)	39
7	psic fees (none allowable expense)	(2,534)	20
8	reclass massage therapy from ln 19 to ln 11	300	11
9	reclass massage therapy from ln 19 to ln 11	(300)	19
10	community relation (non allowable expense)	(952)	20
11	record deprec. On painting reclassified as '09	5,898	6
12	reclass ytd painting-\$1,500 for 2000 from to pg 22	(10,444)	6
13	record deprec. On painting reclassified in 2000	1,741	6
14	Adjust deprec expense to actual	3,649	30
15			15
16	back out non-allow Partnership interest. yr 2000	(31,461)	32
17			17
18			18
19			19
20			20
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82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(149,366)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,374)	0	0	(3,160)	0	0	0	0	0	0	0	(4,534)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(5,105)	0	9,502	0	0	0	0	0	0	0	0	4,397	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,479)	0	9,502	(3,160)	0	0	0	0	0	0	0	(137)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(631)	0	0	0	0	0	0	(631)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,995)	0	0	0	0	0	0	0	0	0	0	(5,995)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(5,995)	0	0	0	(631)	0	0	0	0	0	0	(6,626)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(300)	12,353	(617,600)	0	0	0	0	(38)	0	0	0	(605,585)	19
20	Fees, Subscriptions & Promotions	(37,078)	0	600	0	0	0	0	0	0	0	0	(36,478)	20
21	Clerical & General Office Expenses	0	460	39,991	11,493	7,978	0	0	0	0	0	0	59,922	21
22	Employee Benefits & Payroll Taxes	0	0	57,661	0	(1,227)	0	0	0	0	0	0	56,434	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	15,471	0	0	0	0	0	0	0	0	15,471	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	52,416	164	0	0	0	0	0	0	0	0	52,580	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,378)	65,229	(503,713)	11,493	6,751	0	0	(38)	0	0	0	(457,656)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,852)	65,229	(494,211)	8,333	6,120	0	0	(38)	0	0	0	(464,419)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	18,404	302,796	15,315	0	0	0	0	0	0	0	0	336,515 30
31	Amortization of Pre-Op. & Org.	0	21,414	0	0	0	0	1,548	0	0	0	0	22,962 31
32	Interest	(40,177)	697,786	5,423	0	0	0	2,562	0	0	0	0	665,594 32
33	Real Estate Taxes	0	127,933	6,706	0	0	0	0	0	0	0	0	134,639 33
34	Rent-Facility & Grounds	0	(1,025,084)	0	0	0	0	0	0	0	0	0	(1,025,084) 34
35	Rent-Equipment & Vehicles	0	0	21,207	0	0	0	0	0	0	0	0	21,207 35
36	Other (specify):*	0	44,003	0	0	0	0	0	0	0	0	0	44,003 36
37	TOTAL Ownership	(21,773)	168,848	48,651	0	0	0	4,110	0	0	0	0	199,836 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(113,021)	0	0	(10,295)	(26,963)	0	(63,571)	0	0	0	0	(213,850) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(113,021)	0	0	(10,295)	(26,963)	0	(63,571)	0	0	0	0	(213,850) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(184,647)	234,077	(445,560)	(1,962)	(20,843)	0	(59,461)	(38)	0	0	0	(478,434) 45

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Various- see page 6L...		see page 6k...		see page 6k...		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	rental income	\$ 1,025,084	Valley Ridge Assoc.	0.00%	\$	\$ (1,025,084)	1
2	V	32	interest income	6,304	Valley Ridge Assoc.			(6,304)	2
3	V	33	real estate taxes		Valley Ridge Assoc.		127,933	127,933	3
4	V	30	depreciation		Valley Ridge Assoc.		302,796	302,796	4
5	V	36	mortg. Insurance		Valley Ridge Assoc.		44,003	44,003	5
6	V	26	general insurance		Valley Ridge Assoc.		52,416	52,416	6
7	V	31	amortization		Valley Ridge Assoc.		21,414	21,414	7
8	V	21	gen'l & admin.		Valley Ridge Assoc.		460	460	8
9	V	19	professional fees/accounting		Valley Ridge Assoc.		12,353	12,353	9
10	V	32	mortgage interest		Valley Ridge Assoc.		704,090	704,090	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,031,388			\$ 1,265,465	\$ * 234,077	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 maintenance/utilities	\$	Alden Management Services, Inc.		\$ 9,502	\$ 9,502 15
16	V	19 professional fees	630,621	Alden Management Services, Inc.		13,021	(617,600) 16
17	V	20 licenses/fees		Alden Management Services, Inc.		600	600 17
18	V	21 gen'l & admin		Alden Management Services, Inc.		39,991	39,991 18
19	V	22 employee costs		Alden Management Services, Inc.		57,661	57,661 19
20	V	24 auto/seminar		Alden Management Services, Inc.		15,471	15,471 20
21	V	26 insurance		Alden Management Services, Inc.		164	164 21
22	V	30 depreciation		Alden Management Services, Inc.		15,315	15,315 22
23	V	32 interest		Alden Management Services, Inc.		5,423	5,423 23
24	V	33 real estate tax		Alden Management Services, Inc.		6,706	6,706 24
25	V	35 auto lease		Alden Management Services, Inc.		21,207	21,207 25
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 630,621			\$ 185,061	\$ * (445,560) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube feeding	\$ 21,439	Pyramid Healthcare Services		\$ 18,279	\$ (3,160)	15
16	V	39 nursing supplies	7,754	Pyramid Healthcare Services		7,297	(457)	16
17	V	39 supplies / per diem fees	27,328	Pyramid Healthcare Services		17,490	(9,838)	17
18	V	21 gen'l & admin		Pyramid Healthcare Services		11,493	11,493	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 56,521			\$ 54,559	\$ * (1,962)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 drugs	\$ 73,782	Forum Extended Care II	0.00%	\$ 55,538	\$ (18,244)	15
16	V	10 house stock	2,554	Forum Extended Care II		1,923	(631)	16
17	V	39 iv	35,259	Forum Extended Care II		26,540	(8,719)	17
18	V	22 vaccinations	4,961	Forum Extended Care II		3,734	(1,227)	18
19	V	21 gen'l & admin		Forum Extended Care II		7,978	7,978	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 116,556			\$ 95,713	\$ * (20,843)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 CPT REVENUES	\$ 221,343	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 157,772	\$ (63,571)	15
16	V	31 AMORTIZATION		COMMUNITY PHYSICAL THERAPY		1,548	1,548	16
17	V	32 INTEREST		COMMUNITY PHYSICAL THERAPY		2,562	2,562	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 221,343			\$ 161,882	\$ * (59,461)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Construction management fees	\$ 2,723	Alden Bennett Construction	0.00%	\$ 2,685	\$ (38)	15
16	V	19 architect/design fees	2,418	Alden Design Group		2,418		16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 5,141			\$ 5,103	\$ * (38)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Valley Ridge Rehab & HCC # 0036640 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg	President - AMS	CFO	6.06	182,668	2.42	6.06	Salary	\$ 11,778	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	69,978	2.42	6.06	Salary	4,512	21-1	2
3	Terry Magnusson	Administrator /other	admini / mainten.	b.	28,817	2.42	6.06	Salary	44,803	21-1	3
4	Joan Carl	Vice - President	Secretary	c.	99,519	2.42	6.06	Salary	6,417	21-1	4
5	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	d.	6,551	0.11	0.04	FEES	300	10A-3	5
6											6
7											7
8	a. lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000.										8
9	b. Terry Magnusson is the son-in-law of Floyd Schlossberg. He was the administrator of Alden Valley Ridge for 7 months and in construction / misc. for 5 months in 2000.										9
10	c. Joan Carl is the secretary of AMS and all of the Nursing Facilities. She is the partner in Valley Ridge, Princeton, Cicero, North Shore, Orland Park and Northmoor										10
11	Associates. Which are the partnerships that lease the ANC: Valley Ridge, Princeton, Town Manor, North Shore, Orland Park and Northmoor Nursing Centers.										11
12	d. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										12
13								TOTAL	\$ 67,810		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Valley Ridge Rehab & HCC# 0036640

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ALDEN MANAGEMENT SERVICES, INC.
 Street Address 4200 W. PETERSON
 City / State / Zip Code CHICAGO, IL 60646
 Phone Number (773)286-3883
 Fax Number (773)286-3742

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	SEE PAGE 8A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Cambridge Realty Capital		x	acquisition/remodeling	\$86,836.00	8/28/96	\$ 9,009,300	\$ 8,771,666	9/1/31	8.0000	\$ 704,090	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	RELATED PARTY	x		OPERATIONS	NONE					VARIES	5,423	6	
7	line of credit interest/other		x	OPERATIONS	NONE		900,000	900,000	2/15/01	8.5000	56,374	7	
8	RELATED PARTY-CPT	x		OPERATIONS	NONE					VARIES	2,562	8	
9	TOTAL Facility Related				\$86,836.00		\$ 9,909,300	\$ 9,671,666			\$ 768,449	9	
	B. Non-Facility Related*												
10	V.R.Assoc.-interest income		x	offset interest expense with interest income							(6,304)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (6,304)	14	
15	TOTALS (line 9+line14)						\$ 9,909,300	\$ 9,671,666			\$ 762,145	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	153,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	135,032	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(18,468)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	146,401	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	127,933	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	128,646	8
	1996	129,899	9
	1997	133,585	10
	1998	145,982	11
	1999	135,032	12

2000 ACCRUAL BASED ON AN ESTIMATED 8% INCREASE OF PRIOR YEAR BILL: \$135,032 X 1.08=146401.

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
72,046

B. General Construction Type:

Exterior
BRICK

Frame
STEEL

Number of Stories
3

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
☐ NO

If so, please complete the following:

1. Total Amount Incurred:
759,322

2. Number of Years Over Which it is Being Amortized:
5YEAR/40YEARS

3. Current Period Amortization:
21,414

4. Dates Incurred:
1990-1991

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		1990	\$ 317,223	1
2					2
3	TOTALS			\$ 317,223	3

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	207		1991		\$ 6,027,235	\$ 191,340	30	\$ 200,908	\$ 9,568	\$ 1,992,337	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,644,299	58,820	VARIOUS	64,007	5,187	630,120	9
10	REPAIR A/C,CONTROL SYSTEM & PUMP/MISC.			1991	18,611		5			18,610	10
11	EXHAUST FAN/HVAC/BURNISHER/MISC.			1992	32,815	1,747	5,10 & 15	1,747		23,539	11
12	PIPE INSULATION/HVAC/MISC.			1993	31,308	1,935	5,10,15 & 17	1,935		20,166	12
13	SEWER WORK/CARPETING/ROOFING/INJECTOR PUMP			1994	28,814	1,129	5,10 & 25	1,129		20,538	13
14	REPAIR PUMPS/FAUCETS/HVAC/REGROUT SHOWERS/MSC			1995	28,634	2,272	10,15 & 20	2,272		13,177	14
15	ROOF REPAIR			1996	3,200	320	10	320		1,493	15
16	ROOF REPAIR			1996	2,500	250	10	250		1,104	16
17	PARKING LOT LIGHTING			1996	3,716	248	15	248		1,094	17
18	PARKING LOT LIGHTING,EMRGNCY SERVICE-POWER OUT			1997	8,767	1,753	5	1,753		7,014	18
19	REPAIR PUMP			1997	1,800	360	5	360		1,320	19
20	ROOF REPAIRS			1997	2,590	518	5	518		1,856	20
21	REPLACE COMPRESSOR			1997	6,885	1,377	5	1,377		4,820	21
22	REPLACE MIXING VALVE			1997	2,763	553	5	553		1,888	22
23	REPAIR PUMP			1997	2,161	432	5	432		1,585	23
24	REPLACE PUMP			1997	6,293	1,259	5	1,259		4,615	24
25	REPLACED COMPRESSOR			1997	5,000	1,000	5	1,000		3,167	25
26	ROOF REPAIRS			1997	1,800	360	5	360		1,140	26
27	DOOR HOLDER			1997	4,088	409	10	409		1,261	27
28	PARKING LOT			1997	131,918	6,596	20	6,596		19,264	28
29	INSTALL WALL PLATES/OUTLETS			1997	4,968	497	10	497		1,615	29
30	INSTALL CABLE			1998	5,244	524	10	524		1,267	30
31	CABINETS			1998	73,000	3,650	20	3,650		8,821	31
32	PAINTING			1998	52,000	2,600	20	2,600		6,283	32
33	CARPETING			1998	59,500	2,975	20	2,975		7,190	33
34	DRAPERIES			1998	13,000	650	20	650		1,571	34
35	ROOF			1998	79,000	3,950	20	3,950		9,546	35
36	TOTAL (lines 4 thru 35)				\$ 8,281,909	\$ 287,524		\$ 302,279	\$ 14,755	\$ 2,806,400	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		OIL/DRIER ON STAGE COMPRESSOR		1998	2,900	193	15	193		532	9
10		REPAIR TOWER		1998	2,727	182	15	182		455	10
11		REPLACE PRESSURE RELIEF VALVE		1998	1,940	129	15	129		323	11
12		CARPETING		1998	1,667	333	5	333		806	12
13		CARPETING		1998	15,858	3,172	5	3,172		7,400	13
14		CARPETING		1998	5,000	1,000	5	1,000		2,333	14
15		REPAIR FUEL PUMP ON GENERATOR		1998	2,532	127	20	127		295	15
16		FLOOR TILE		1998	4,876	488	10	488		1,097	16
17		REPAIR SHAFT AND GEAR REDUCER ON DRYER		1998	2,058	206	10	206		463	17
18		REPAIR VALVE IN THERAPY ROOM		1998	1,505	100	15	100		217	18
19		REPLACE HEAT PUMP		1998	3,773	252	15	252		545	19
20		CARPETING		1998	20,000	4,000	5	4,000		8,667	20
21		CARPETING		1998	18,082	3,616	5	3,616		7,836	21
22		Alden Bennet Construction (tank replacement)		1999	12,409	827	15	827		1,586	22
23		Northtown (repair dishwasher)		1999	1,695	170	10	170		325	23
24		Climate Service (replace hot water heater)		1999	9,561	637	15	637		1,116	24
25		Taylor Plumbing (pump repair)		1999	1,728	346	5	346		605	25
26		Ashland Plumbing & Heating Co. (furnished and installed ejector pump)		1999	6,658	444	15	444		740	26
27		Rykoff-Sexton (booster heater)		1999	1,893	189	10	189		316	27
28		Climate Service (cleaned condenser and tower)		1999	2,642	264	10	264		418	28
29		Patten Industries(generator repair)		1999	2,870	287	10	287		431	29
30		Fox Valley Fire & Safety(nurse call system repair)		1999	1,510	101	15	101		126	30
31		Fox Valley Fire & Safety(nurse call system repair)		1999	1,632	109	15	109		136	31
32		Climate Service(repair tower fan)		1999	4,733	473	10	473		592	32
33		Climate Service(repair tower fan)		1999	2,405	241	10	241		301	33
34		New Horizons(replace power supply for phone system)		1999	3,767	377	10	377		471	34
35		CONTINUE ON PG 12B...									35
36		TOTAL (lines 4 thru 35)			\$ 136,422	\$ 18,262		\$ 18,262	\$	\$ 38,129	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	\$ 12,184	\$ 554	22	\$ 554		\$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 58,177	\$ 3,514		\$ 3,514		\$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Patten Industries(rebuild generator)			1999	7,884	394	20	394		427	9
10	Alco(nuts, bolts, lock extensions, tube cap,head screw)			1999	1,779	356	5	356		385	10
11	System Electric(repair dedicated circuits)			2000	2,461	150	15	150		150	11
12	Capps Plumbing (repair ejector pumps)			2000	4,970	304	15	304		304	12
13	Fox Valley (re-wire smoke detectors)			2000	14,576	1,093	10	1,093		1,093	13
14	Harold(repair dish machine)			2000	962	64	5	64		64	14
15	Harold(repair dish machine)			2000	1,328	66	5	66		66	15
16	new horizons-install phone line			2000	2,742	137	10	137		137	16
17	ABC-miscell. Construct.maint. Work			2000	835	14	5	14		14	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 37,537	\$ 2,579		\$ 2,579	\$	\$ 2,641	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 875,631	\$ 69,094	\$ 69,094	\$	vary	\$ 609,655	37
38	Current Year Purchases	38,497	2,618	2,618		vary	2,618	38
39	Fully Depreciated Assets	49,792	1,214	1,214		vary	49,792	39
40								40
41	TOTALS	\$ 963,920	\$ 72,926	\$ 72,926	\$		\$ 662,065	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	van, busses, engine	1998-2000	\$ 26,682	\$ 2,494	\$ 2,494	\$	3	\$ 3,060	42
43		1998-2000								43
44										44
45										45
46	TOTALS			\$ 26,682	\$ 2,494	\$ 2,494	\$		\$ 3,060	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 9,821,869	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 387,299	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 402,054	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 14,755	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,727,526	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RELATED PARTY (VALLEY RIDGE ASSOCIATES)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 8,125 Description: COPY MACHINE LEASE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related Party</u>		\$	\$	17
18	<u>see page 8A</u>	<u>Various</u>	<u>1767</u>	<u>21,207</u>	18
19					19
20					20
21	TOTAL		\$ 1767	\$ 21,207	21

10. Effective dates of current rental agreement:

Beginning 2/1/91

Ending 1/31/2010

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/01 \$ 1116K

13. 12/31/02 \$ 1116K

14. 12/31/03 \$ 1116K

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>SKILLED NURSING IS ALREADY ON SITE</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <input type="text"/></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <input type="text"/></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 99,746	\$		\$ 99,746	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,636			7,636	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			114,079			114,079	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG 16A...	# of prescrpts				45,019		45,019	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PG 16A....					39,504		39,504	13
14	TOTAL			\$		\$ 221,461	\$ 84,523		\$ 305,984	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 185,877	\$ 192,524	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (245,520))	1,494,938	1,494,938	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,467	151,449	6
7	Other Prepaid Expenses	17,009	49,829	7
8	Accounts Receivable (owners or related parties)	703,495	703,495	8
9	Other(specify): misc. reciev /other escrows		69,202	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,456,287	\$ 2,661,937	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		304,366	13
14	Buildings, at Historical Cost		7,880,053	14
15	Leasehold Improvements, at Historical Cost	450,168	785,586	15
16	Equipment, at Historical Cost	294,896	893,830	16
17	Accumulated Depreciation (book methods)	(418,180)	(3,328,579)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		887,277	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,884	\$ 7,422,533	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,783,171	\$ 10,084,470	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,511,646	\$ 1,512,106	26
27	Officer's Accounts Payable	262,600	262,600	27
28	Accounts Payable-Patient Deposits	225,793	225,793	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,428	122,428	30
31	Accrued Taxes Payable (excluding real estate taxes)	73,043	73,043	31
32	Accrued Real Estate Taxes(Sch.IX-B)		144,000	32
33	Accrued Interest Payable		58,478	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	third party	515,443	1,229,200	36
37	due idpa / other accr exps.	616,079	663,730	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,327,032	\$ 4,291,378	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,771,666	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,771,666	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,327,032	\$ 13,063,044	46
47	TOTAL EQUITY(page 18, line 24)	\$ (543,861)	\$ (2,978,574)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,783,171	\$ 10,084,470	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (118,352)	1
2	Restatements (describe):		2
3	external audit adjustment done after 1999 cost report filed		3
4	which have no effect on reimbursement cost: bad debt expenses,		4
5	medicare revenues	(152,250)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (270,602)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(273,159)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) treasury stock	(100)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (273,259)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (543,861)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,992,637	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,992,637	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	125,199	6
7	Oxygen	40,162	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 165,361	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,493	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,150	21
22	Laundry	135	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,778	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,171,777	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,609,184	31
32	Health Care	2,515,090	32
33	General Administration	1,491,886	33
B. Capital Expense			
34	Ownership	1,195,299	34
C. Ancillary Expense			
35	Special Cost Centers	519,834	35
36	Provider Participation Fee	113,643	36
D. Other Expenses (specify):			
37	Note: will not balance with pages 3 & 4 due to related party		37
38	amounts input into page 3 & 4.		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,444,936	40
41	Income before Income Taxes (line 30 minus line 40)**	(273,159)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (273,159)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

0036640

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,896	2,080	\$ 65,288	\$ 31.39	1
2	Assistant Director of Nursing	1,536	1,883	45,163	23.98	2
3	Registered Nurses	25,310	28,077	617,340	21.99	3
4	Licensed Practical Nurses	21,148	22,957	476,964	20.78	4
5	Nurse Aides & Orderlies	75,086	79,762	973,089	12.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	871	879	11,594	13.19	7
8	Rehab/Therapy Aides					8
9	Activity Director	6,771	7,339	70,433	9.60	9
10	Activity Assistants	9,553	9,984	96,698	9.69	10
11	Social Service Workers	1,908	2,099	35,178	16.76	11
12	Dietician	22,346	24,134	149,582	6.20	12
13	Food Service Supervisor	1,896	2,088	51,949	24.88	13
14	Head Cook	6,454	7,088	67,871	9.58	14
15	Cook Helpers/Assistants	10,341	10,880	90,086	8.28	15
16	Dishwashers					16
17	Maintenance Workers	1,891	2,112	44,460	21.05	17
18	Housekeepers	19,534	21,410	177,600	8.30	18
19	Laundry	8,270	8,724	73,457	8.42	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	5,226	6,205	74,003	11.93	22
23	Office Manager	4,974	5,328	59,549	11.18	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,771	2,111	52,543	24.89	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Clinical Supp.Sup.	1,712	2,096	44,015	21.00	33
34	TOTAL (lines 1 - 33)	228,494	247,236	\$ 3,276,862 *	\$ 13.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,421	11-3	44
45	Social Service Consultant	12	618	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	59	\$ 3,039		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name		Function	%	Amount	Description		Amount	Description		Amount	
CHARLEAN ADAMS		ADMINISTRATOR		\$ 28,558	Workers' Compensation Insurance		\$ 53,061	IDPH License Fee		\$	
TERRY MAGNUSSON		ADMINISTRATOR		42,945	Unemployment Compensation Insurance		30,484	Advertising: Employee Recruitment		1,370	
					FICA Taxes		244,896	Health Care Worker Background Check (Indicate # of checks performed)			
					Employee Health Insurance		115,048	Misc. Subscriptions (IHCA and others)		10,217	
					Employee Meals		42,506	City and County License & inspections		825	
					Illinois Municipal Retirement Fund (IMRF)*						
					REALTED PARTY		56,434				
					DENTAL / LIFE INSURANCE		3,979	Related Party		600	
					EMP. RELATIONS / EMP. VACC. /EMP. PHY.		7,093				
					PAYROLL MISC. COST / TUITION REIMB		4,443				
					401K MATCH		1,455				
								Less: Public Relations Expense		()	
								Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 71,503	TOTAL (agree to Schedule V, line 22, col.8)		\$ 559,400	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 13,012
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description				Amount	Description		Line #	Amount	Description		Amount
				\$				\$	Out-of-State Travel		\$
									In-State Travel		
									AUTO & TRAVEL		583
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$					Seminar Expense		
C. Professional Services									SEMINARS		750
Vendor/Payee		Type		Amount							
ALDEN MANAGEMENT SVS		MGMT. FEES		\$ 630,621					Related Party		15,471
BALCKMAN KALLCK		ACCOUNTING		11,022					Entertainment Expense		()
KENNETH F. /B. GREENBURG H. LEGAL				32,905					(agree to Sch. V, line 24, col. 8)		
AUDRA SCHLOSSBERG		massage therapy **		300					TOTAL		\$ 16,804
VARIOUS PRO. FEES		PRO. FEES(include 1999 adj)		(8,382)							
ALDEN DESIGN		DESIGN FEES		2,418							
ALDEN BENNET CONSTRUCTION		CONSTRUCATION FEES		2,723							
US GAS & ENERGY		UTILITY CONSULT		776							
** reclassified to line 10a on page 3											
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 672,383	TOTAL			\$			

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting/hvac/pump rep's	2-10/92	\$ 6,223	5	\$ 1,245	\$ 326	\$	\$	\$	\$	\$	\$	\$
2	Plumbing/painting	7-10/94	10,767	5	2,153	2,153	1,460						
3	Painting/hvac repairs	1-12/95	14,370	3-10	4,791	1,757	0						
4	Painting/hvac damper rep	1-12/96	21,136	3-10	5,515	5,513	2,838	656	656	656	656	656	656
5	sprinklers/hvac repairs	5-11/97	12,867	3	1,300	4,289	4,289	2,989	0				
6	hvac repair	6/98	2,089	3		406	696	696	290	0			
7	painting>\$1,500 ytd 1999	7/99	10,794	3			1,799	3,598	3,598	1,799	0		
8	ABC(repair pole)	9/00	1,278	3				142	426	426	284	0	
9	GT Mech.(repair A/C)	8/00	1,545	3				214	515	515	301	0	
10	painting>\$1,500 ytd 2000	7/00	10,444	3				1,741	3,481	3,481	1,741	0	
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 91,513		\$ 15,004	\$ 14,444	\$ 11,082	\$ 10,036	\$ 8,966	\$ 6,878	\$ 2,982	\$ 656	\$ 656

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Healthcare Assoc. \$10,217
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,652 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 113,643
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 42,506 Has any meal income been offset against related costs? NONE Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.